ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
HAMSA M. MURTHY
Deputy Attorney General
State Bar No. 274745
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3495
Facsimile: (415) 703-5480
*Attorneys for Complainant*

**BEFORE THE**
**PHYSICIAN ASSISTANT BOARD**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against**:**<br><br>**DOROTHY TSENG YIP, P.A.**<br><br>**Berkeley Family Practice**<br>**2637 Shadelands Drive**<br>**Walnut Creek, CA 94598**<br>**Physician Assistant License No. PA 52283**<br><br>Respondent. | Case No. 950-2020-002932<br><br>**ACCUSATION** |

## PARTIES

1. Rozana Khan (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs.

2. On February 6, 2015, the Physician Assistant Board issued Physician Assistant License Number PA 52283 to Dorothy Tseng Yip, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2022, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Physician Assistant Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

> (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a PA license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board.
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> (b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.
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> (c) The board may order the denial of the application for, or the suspension or revocation of, or the imposition of probationary conditions upon, a PA license, after a hearing as required in Section 3528 for unprofessional conduct that includes, except for good cause, the knowing failure of a licensee to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the Osteopathic Medical Board of California, the Podiatric Medical Board of California, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California to encourage appropriate consistency in the implementation of this subdivision.
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> The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of bloodborne infectious diseases.
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> (d) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

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(e) The expiration, cancellation, forfeiture, or suspension of a PA license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

5. Section 3528 of the Code states:

Any proceedings involving the denial, suspension, or revocation of the application for licensure or the license of a PA or the application for approval or the approval of an approved program under this chapter shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

6. California Code of Regulations, title 16, section 1399.521 states:

In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the board may deny, issue subject to terms and conditions, suspend, revoke or place on probation a physician assistant for the following causes: (a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon. (b) Using fraud or deception in passing an examination administered or approved by the board. (c) Practicing as a physician assistant under a physician who has been prohibited by the Medical Board of California or the Osteopathic Medical Board of California from supervising physician assistants. (d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations.

7. Section 2234 of the Code states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

**COST RECOVERY**

9. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

**FIRST CAUSE FOR DISCIPLINE**

**(Unprofessional Conduct/ Repeated Negligent Acts/ Gross Negligence)**

10. Respondent's license is subject to disciplinary action under California Code of Regulations, title 16, section 1399.521, and/or sections 3527 and/or 2234 of the Code in that Respondent engaged in unprofessional conduct and/or committed repeated acts of negligence and/or gross negligence in her care and treatment of a patient, who is referred to as "Patient 1" to protect privacy. The circumstances are as follows:

11. Respondent worked as a Physician Assistant at a family practice clinic in Walnut Creek, CA in 2017. At the clinic, Respondent saw Patient 1, a fifty-two year old man, for an initial primary care office visit on March 8, 2017. On March 8, 2017, Respondent prescribed to Patient 1 a medication (Lisinopril, 10 mg/ day) for his hypertension, which had persisted since 2015. Patient 1 was also noted to have a "strong family history" of hypertension and a father with irregular heartbeat. At a follow up office visit on April 3, 2017, Respondent increased Patient 1's dosage of Lisinopril to 20 mg/ day due to persistent hypertension. A blood test previously ordered by Respondent and collected on June 8, 2017 showed that Patient 1 also had elevated

cholesterol and triglycerides. On September 29, 2017, Respondent saw Patient 1 again for follow up regarding his hypertension and for hemorrhoids. On September 29, 2017, Respondent noted that Patient 1's hypertension was "not well controlled" and increased his dosage of Lisinopril to 30 mg/ day. She also discussed with Patient 1 reducing sugar and carbohydrate intake due to his elevated triglycerides and cholesterol levels.

12. On November 15, 2017, Patient 1 saw Respondent for an office visit. At the office visit, Patient 1 reported to Respondent acute shortness of breath and getting winded easily during the previous two weeks. He also reported feeling "out of shape" when biking, an activity he typically did with ease. Although Patient 1 denied chest pain or coughing, he reported shortness of breath when walking on flat ground in the previous forty-eight hours, and also heart palpitations. Respondent's assessment of Patient 1 included: dyspnea on exertion; premature ventricular contraction; and T wave inversion on EKG. Respondent lowered Patient 1's dosage of Lisinopril to 10 mg/day but also started him on Metoprolol Succinate (100 mg/day) and aspirin (162 mg/ day). Respondent instructed Patient 1 to take the Metoprolol for tachycardia. Although Respondent did not send Patient 1 to an emergency room, she and office staff secured an urgent, non-emergent appointment for Patient 1 to be seen by a cardiologist four days later. Respondent also prescribed nitroglycerin to Patient 1 and advised him to use it sublingually in the event of chest pain. Respondent instructed Patient 1 to go to an emergency room at the first sign of chest pain. Respondent did not examine Patient 1's lower extremities for edema or calf tenderness to rule out possible heart failure and possible deep vein thrombosis.

13. On November 17, 2017, Patient 1 phoned Respondent's office and spoke to Respondent. Patient 1 reported that his shortness of breath was getting worse, and that he was feeling anxious. Respondent explained to Patient 1 that sometimes anxiety and cardiac symptoms are overlapping. Respondent electronically prescribed Ativan, an anti-anxiety medication, to Patient 1. She also told Patient 1 to go to the emergency room if he did not feel better after taking the Ativan. Respondent, however, did not record in Patient 1's medical record in the progress notes that Patient 1 had been so advised and/or that she explained to Patient 1 and/or made certain

that Patient 1 understood the risks of not going to the emergency room at that time.

14. On November 18, 2017 at around noon, Patient 1 phoned Respondent's office again. Respondent spoke to Patient 1, who reported that he had just walked to the pharmacy to pick up the Ativan prescription and was experiencing shortness of breath. Respondent told Patient 1 to go to the emergency room, but she did not record in Patient 1's medical records in the progress notes that Patient 1 had been so advised and/or that she explained to Patient 1 and/or made certain that Patient 1 understood the risks of not going to the emergency room at that time.

15. Respondent told Patient 1 to take the Ativan at the pharmacy and then come by rideshare service to her office, where she could further evaluate him. On November 18, 2017, Patient 1 arrived at around 1:00 or 1:30 p.m. at Respondent's office for another office visit. Respondent recorded that Patient 1 presented with worsening shortness of breath since his last office visit three days before. Respondent did not examine Patient 1's lower extremities for edema or calf tenderness to rule out possible heart failure and possible deep vein thrombosis. In addition, Respondent also failed to recognize the significance of Patient 1's increased systems and/or failed to document in Patient 1's medical record in the progress notes that she communicated to Patient 1 the risks of not going to the emergency room at that time, and that Patient 1 understood those risks.

16. On November 19, 2017, Patient 1 died at his home at approximately 2:15 p.m.

17. The allegations set forth in Paragraphs 10 through 16 are hereby incorporated by reference herein. Respondent is guilty of unprofessional conduct, and Respondent's license is subjected to discipline pursuant to California Code of Regulations, title 16, section 1399.521, and/or sections 3527 and/or 2234 of the Code based on Respondent's commission of repeated negligent acts and/or gross negligence, including but not limited to the following:

A. Respondent's failure to examine Patient 1's legs for edema and/or calf tenderness on November 15, 2017 at the office visit with Patient 1;

B. Respondent's failure to examine Patient 1's legs for edema and/or calf tenderness on November 18, 2017 at the office visit with Patient 1;

C. Respondent's failure to recognize the significance of Patient 1's increased symptoms on the November 17, 2017 telephone call with Patient 1, and/or her failure to record in Patient 1's medical record in the progress notes that she advised Patient 1 to go to the emergency room and/or that she explained to Patient 1 the risks of not going to the emergency room at that time and/or made certain that Patient 1 understood those risks;

D. Respondent's failure to recognize the significance of Patient 1's increased symptoms on the November 18, 2017 telephone call with Patient 1, and/or her failure to record in Patient 1's medical record in the progress notes that she advised Patient 1 to go to the emergency room and/or that she explained to Patient 1 the risks of not going to the emergency room at that time and/or made certain that Patient 1 understood those risks;

E. Respondent's failure to recognize the significance of Patient 1's increased symptoms during the November 18, 2017 office visit with Patient 1 and/or her failure to document in Patient 1's medical record in the progress notes that she explained to Patient 1 the risks of not going to the emergency room at that time and/or made certain that Patient 1 understood those risks.

**SECOND CAUSE FOR DISCIPLINE**
**(Failure to Maintain Adequate and Accurate Patient Records)**

18. The allegations set forth in Paragraphs 10 through 16 are hereby incorporated by reference herein. Respondent's license is subjected to discipline pursuant to California Code of Regulations, title 16, section 1399.521, and/or sections 3527 and/or 2266 of the Code due to Respondent's failure to maintain adequate and accurate patient records for Patient 1, including but not limited to Respondent's failures to document in Patient 1's medical record in the progress notes Patient 1's multiple informed refusals to go to the emergency room between November 15, 2017 and November 18, 2017, when she had multiple encounters with Patient 1.

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## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 52283, issued to Dorothy Tseng Yip, P.A.;

2. Ordering Dorothy Tseng Yip, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Ordering Dorothy Tseng Yip, P.A., if placed on probation, to pay the Physician Assistant Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 21, 2022

Kristy Voong for
ROZANA KHAN
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
*Complainant*

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